Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

LESLIE D JENNINGS MD
4323 N JOSEY LANE STE 307
CARROLLTON TX 75010-4630

Respondent Name
Liberty Insurance Co

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-13-2983-01

MFDR Date Received
July 10, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This procedure should have been paid. It is documented and separately reimburseable."

Amount in Dispute: $2,700.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The 59 modifier was not supported as the operative report documents the performance of the synovectomy in the same compartments (medial and lateral) as the partial medical and lateral meniscectomy and of the same left knee.."

Response Submitted by: Liberty Insurance Corp

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 8, 2012	29876 (59)	$2,700.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.307, 33 sets out the procedures for resolving medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes;
   - B291 – THIS IS A BUNDLED OR NON COVERED PROCEDURE BASED ON MEDICARE GUDELINES. NO SEPARATE PAYMENT ALLOWED.
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, T WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

1. Did the requestor support use of the 59 modifier?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing, reporting and reimbursement of professional medical services. Texas Workers' Compensation system participants shall apply the following; (1) Medicare payment policies, including its coding; billing; … and other payment policies in effect on the date a service is provided…" The medical bill for the service in dispute included the "59" modifier. American Medical Association Current Procedural Terminology (AMA CPT) describes the 59 modifier for use in identifying procedures/services that are not normally reported together, and that are not ordinarily encountered or performed on the same day by the same physician. According to Medicare Learning Network Matters (MLN) Number, SE0715, these would include a different session or patient encounter, procedure or surgery, site or organ system; or a separate incision/excision, lesion, or injury (or area of injury in extensive injuries). The medical documentation including the document titled "Operative Report" was reviewed but did not support the service in dispute represents a separate service. The division concludes that the requestor did not meet the requirements of §134.203(b)(1).

2. The requestor billed 29876 but did not support the use of the 59 modifier, consequentlycode 29875 cannot e considered a separate service. Appliction of Correct Coding Initiative (CCI) edits in accordance with 28 Texas Administrative Code §134.203(b)(1) indicate 29876 is not separately payable when billed along with 29880.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

Authorized Signature

		November 25, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.